EXECUTIVE SUMMARY

PURPOSE

To (1) review State Medicaid cost sharing policies and (2) determine their impact on the program.

BACKGROUND

Medicaid is one of the fastest growing programs in Federal and State budgets. Total Medicaid expenditures grew from $72.1 billion in 1990 to $94.5 billion in 1991, an increase of 31 percent. As Medicaid costs continue to rise, Federal and State officials are searching for cost containment measures.

One of the fastest growing trends in corporate health care cost containment is greater beneficiary cost sharing. Cost sharing requires beneficiaries to pay a portion of their health care costs. State Medicaid programs have also increasingly been using cost sharing as a cost containment method. States not currently using cost sharing policies may begin to reexamine the issue since Medicaid now absorbs 14 cents of every State dollar spent.

Section 1902(a)(14) of the Social Security Act provides that Medicaid may impose "enrollment fees, premiums, or similar charges, and deductions, cost sharing, or similar charges." Children, HMO enrollees, pregnancy services, emergency services, hospice services, and services provided to residents of nursing facilities or medical institutions, are exempt from cost sharing.

To examine States' cost sharing policies, we collected detailed information from State Medicaid directors. We also reviewed data collected by the Health Care Financing Administration's (HCFA) information systems.

FINDINGS

Twenty-seven States use cost sharing in their Medicaid programs.

Cost sharing programs save money.

States without cost sharing could save between $167 and $335 million annually (of which the Federal share would be $99 to $198 million) by applying cost sharing to just four services -- inpatient hospital, outpatient hospital, physician visits, and prescription drugs.

States with cost sharing do not report significant impacts on utilization of services or access to care.

Cost sharing States have not experienced excessive administrative, recipient, or provider burdens.

Federal requirements may hinder States from designing even more effective cost sharing programs.

RECOMMENDATION

We believe that implementing or expanding cost sharing programs would allow States to (1) reduce program expenditures; (2) maintain or increase eligible populations; (3) maintain or increase covered services; and/or (4) maintain or increase reimbursement rates.

As a result of these conclusions, we make the following recommendation.

The HCFA should promote the development of effective cost sharing programs by:

- allowing States to experiment with cost sharing programs that target new populations and reflect more substantial cost sharing amounts, and/or
- recommending changes to Federal requirements allowing for greater State flexibility in determining exempted populations and services, and allowing higher recipient cost sharing amounts.

The HCFA might also consider funding evaluation projects which formally assess cost sharing programs and provide information on the most effective structure of such programs.

The HCFA should promote the use of cost sharing in States that do not currently have programs. The HCFA could choose to exercise its leadership in a number of ways. The HCFA could:

- encourage States to implement cost sharing by providing information about State experiences with cost sharing and offering technical assistance and clarification of Federal requirements, or
- seek legislation to provide States with incentives to implement cost sharing programs, such as decreasing Federal matching to States who do not implement cost sharing, or
- seek legislation to mandate cost sharing for all States.

AGENCY COMMENTS

The HCFA and the Assistant Secretary for Management and Budget commented on the draft report; the full text of their comments is in Appendix D. Neither agency concurred with our draft recommendation. We have made several changes in response to their suggestions. However, we believe that the available evidence supports cost-sharing as a viable cost saving mechanism for financially strapped State programs, and would have a less deleterious effect on Medicaid beneficiaries than poor payment rates to providers, or elimination of services or eligible groups.